

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-025358

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 296

Primary Registration District No. 4410

Registrar's No. 28

STATE FILE NUMBER

FILED JUN 20 1963

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Phelps	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. James		c. CITY OR TOWN St. James	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Soldiers Home Hospital		d. STREET ADDRESS (If outside, give location) 620 N. Jefferson	

3. NAME OF DECEASED (Type or print) First Elizabeth Middle Rackley Last	4. DATE OF DEATH Month June Day 14, Year 1963
---	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-16-1878	9. AGE (last birthday) 85	10. IF UNDER 1 YEAR Months 2 Days 28	11. IF UNDER 24 HR Hours Min.
------------------	---------------------------	---	-------------------------------	------------------------------	---	----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Indiana	12. CITIZEN OF WHAT COUNTRY USA
--	---	---	------------------------------------

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE James (Dee)
-------------------------------	--------------------------------------	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) no	16. SOCIAL SECURITY NO. no	17. INFORMANT Soldiers Home, St. James, Mo.
--	-------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Organic heart disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i> <i>5 yr</i> <i>5 yr</i>
---	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	---	--

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
---------------------------------------	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	--	--

21. I attended the deceased from Dec '62 to 6-14-63 and last saw him alive on 6-13-63 Death occurred at 3:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. D. Tucker MD</i>	22b. ADDRESS St James Mo	22c. DATE SIGNED 6-15-63
--	-----------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-15-1963	23c. NAME OF CEMETERY OR CREMATORY Soldiers Home Cemetery	23d. LOCATION (City, town, or county) St. James, Mo.
---	------------------------	--	---

24. FUNERAL DIRECTOR <i>James Gahr</i>	25. DATE RECD. BY LOCAL REG. 6-17-1963	26. REGISTRAR'S SIGNATURE <i>Ruth B. Powell</i>
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

10810

20810

3

4 /

5 3

6

7 /

8 2

9443X

10

11

12 86-0

13 2-0

NOV 29 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer.

Signed C. Jesse Gahr

Licensed Embalmer No. 4486

P. O. Address St. James, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Received Serial 6-15-63 according to M.O. signature

R.A.P.